Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS HEALTH FORT WORTH
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
Travelers Indemnity Co

Carrier's Austin Representative Box
Box Number 05

MFDR Tracking Number
M4-12-1821-01

MFDR Date Received
January 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medicare would have allowed this facility $1,729.03 at 200% of MAR and Texas fee schedule allows $3,981.81 per the OUTLIER calculations. …Based on their payment of $2,103.45, a supplemental payment of $1878.35 is due."

Amount in Dispute: $1,878.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers Indemnity Co

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 8 through July 10, 2011	Outpatient Hospital Services	$1,878.35	$281.64

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §134.403 defines Outpatient medical services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 14, 2011
   - INCL- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PACKAGED

SERVICES ARE INCLUDED IN THE APC RATE.

- FEES - W1 – W1 WORKERS COMPENSATION STATE F/S ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC.
- GL10 – 89 – PROFESSIONAL FEES REMOVED FROM CHARGES. SERVICES BILLED FOR RADIOLOGY, LAB, AND/OR PATHOLOGY BY A HOSPITAL SHOULD NORMALLY BE BILLED AT THE TC RATE.
- TXNC – 96 – NON COVERED CHARGE(S). NON COVERED SERVICES PER THE TX HOSPITAL MEDICAARE METHODOLOGY PER RULE 134.403(D).
- TXAP - W1 – WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. PRICED ACCORDING TO THE STATE APC FEE SCHEDULE RATE.
- TXGC - W1 – WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. MAR AMOUNT IS GREATER THAN THE CHARGED AS PER TEXAS HOSPITAL GUIDELINES.
- TXOB – 173 – PAYMENT IS ADJUSTED BECAUSE THIS SERVICE WAS NOT PRESCRIBED BY A PHYSICIAN. DIRECT ADMISSION TO OBSERVATIONS IS REIMBURSED AFTER BEING SEEN BY A COMMUNITY PHYSICIAN PER RULE 134.403(D).

Explanation of benefits dated January 13, 2012

- 193/# - AFTER CAREFULLY REVIEWING THE RESUBMITTED INVOICE, ADDITIONAL REIMBURSEMENT IS NOT JUSTIFIED

Issues

1. Were the services in dispute classified correctly?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent contends the disputed services should be calculated based on an "in-patient" rather than "out-patient" status. 28 Texas Administrative Code §134.403(4) defines outpatient as, "Outpatient" means the patient is not admitted for inpatient or residential care. Outpatient medical services includes observation in an outpatient status provided the observation period complies with Medicare policies." Therefore the division finds the Carriers position is not supported. The services in dispute will be calculated as stated below.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
   - Procedure code 36415, date of service July 9, 2011, has a status indicator of A, which denotes services paid

under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. This amount multiplied by 2 units is $6.00. 125% of this amount is $7.50

- Procedure code 36415, date of service July 10, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
- Procedure code G0434, date of service July 9, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Payment for this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(d)(1). The fee listed for this code in the Medicare DMEPOS fee schedule is $15.64. 125% of this amount is $19.55
- Procedure code 80048, date of service July 9, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.91. 125% of this amount is $14.89
- Procedure code 80048 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.91. 125% of this amount is $14.89
- Procedure code 80048, date of service July 10, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.91. 125% of this amount is $14.89
- Procedure code 80100, date of service July 9, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $15.64. This amount multiplied by 3 units is $46.92. 125% of this amount is $58.65
- Per the Centers for Medicare Services, (CMS), National Corrective Coding Initiatives (CCI) edits, procedure code 80101 and 80100 should not be reported together when performed on the same date unless an appropriate modifier is appended to the component code to differentiate between the services provided. This procedure is a component service of procedure code 80100 performed on the same date. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service without a modifier; therefore, separate payment is not recommended.
- Procedure code 82055, date of service July 9, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical

Fee Schedule is $15.21. 125% of this amount is $19.01

- Procedure code 82272 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.58. 125% of this amount is $5.73
- Procedure code 84484 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $13.85. 125% of this amount is $17.31
- Procedure code 85025, date of service July 9, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $10.94. 125% of this amount is $13.68
- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $10.94. 125% of this amount is $13.68
- Procedure code 81001, date of service July 9, 2011, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.45. 125% of this amount is $5.56
- Procedure code 71010 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code 74176 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC ; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0332, which, per OPPS Addendum A, has a payment rate of $193.85. This amount multiplied by 60% yields an unadjusted labor-related amount of $116.31. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $111.20. The non-labor related portion is 40% of the APC rate or $77.54. The sum of the labor and non-labor related amounts is $188.74. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $188.74. This amount multiplied by 200% yields a MAR of $377.48.
- Procedure code 76770, date of service July 9, 2011, has a status indicator of Q3, which denotes

conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0266, which, per OPPS Addendum A, has a payment rate of $96.28. This amount multiplied by 60% yields an unadjusted labor-related amount of $57.77. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $55.23. The non-labor related portion is 40% of the APC rate or $38.51. The sum of the labor and non-labor related amounts is $93.74. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $93.74. This amount multiplied by 200% yields a MAR of $187.48.

- Procedure code 94640 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0077, which, per OPPS Addendum A, has a payment rate of $28.73. This amount multiplied by 60% yields an unadjusted labor-related amount of $17.24. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $16.48. The non-labor related portion is 40% of the APC rate or $11.49. The sum of the labor and non-labor related amounts is $27.97 multiplied by 2 units is $55.94. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $55.94. This amount multiplied by 200% yields a MAR of $111.88.
- Procedure code 96361 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0436, which, per OPPS Addendum A, has a payment rate of $26.35. This amount multiplied by 60% yields an unadjusted labor-related amount of $15.81. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $15.12. The non-labor related portion is 40% of the APC rate or $10.54. The sum of the labor and non-labor related amounts is $25.66. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $25.66. This amount multiplied by 200% yields a MAR of $51.32.
- Per the Centers for Medicare Services, (CMS), National Corrective Coding Initiatives (CCI) edits, procedure code 96374 and 99285 should not be reported together when performed on the same date unless an appropriate modifier is appended to the component code to differentiate between the services provided. This procedure is a component service of procedure code 99285 performed on the same date. Separate payment for the services billed may be justified if a modifier is used appropriately. The requestor billed the disputed service without a modifier; therefore, separate payment is not recommended.
- Procedure code 99285 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003. This service meets the criteria for composite payment. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. The payment for composite services is calculated below.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2310, date of service July 9, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405, date of service July 9, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7030, date of service April 8, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J7030, date of service July 9, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J7030, date of service July 10, 2011, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of $27.26. This amount multiplied by 60% yields an unadjusted labor-related amount of $16.36. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $15.64. The non-labor related portion is 40% of the APC rate or $10.90. The sum of the labor and non-labor related amounts is $26.54. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $26.54. This amount multiplied by 200% yields a MAR of $53.08.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure codes 99285, and 71010, date of service July 8, 2011, have a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8003, for level II extended assessment and management services. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges. Total packaged cost is allocated to the composite line-item in proportion to other separately paid services on the claim. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 8003, which, per OPPS Addendum A, has a payment rate of $714.33. This amount multiplied by 60% yields an unadjusted labor-related amount of $428.60. This amount multiplied by the annual wage index for this facility of 0.9561 yields an adjusted labor-related amount of $409.78. The non-labor related portion is 40% of the APC rate or $285.73. The sum of the labor and non-labor related amounts is $695.51. The cost of these services does not exceed the annual fixed-dollar threshold of $2,025. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $695.51. This amount multiplied by 200% yields a MAR of $1,391.02.

4. The total allowable reimbursement for the services in dispute is $2,385.10. This amount less the amount previously paid by the insurance carrier of $2,103.46 leaves an amount due to the requestor of $281.64. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $281.64.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $281.64, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 8, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.